Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

FOUNDATION SURGICAL HOSPITAL
322 SOUTHWEST FREEWAY SUITE 2200
HOUSOTN TX 77027

Respondent Name
American Interstate Insurance

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-10-1126-01

MFDR Date Received
October 15 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The surgery was preauthorized by Coventry."

Amount in Dispute: $898.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…Utilization Review approved ESI Injection only."

Response Submitted by: American Risk Services, Inc. 2301 Hwy 190 West, DeRidder, LA 70034

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 15, 2008	Outpatient Hospital Services	$898.40	$898.40

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective review of health care.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 198 – Precertification/authorization exceeded.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Did the respondent support the insurance carrier's reasons for reduction or denial of services?

2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed services with reason code 198 – "Precertification/authorization exceeded." Per 28 Texas Administrative Code §134.600(c)(1), effective May 2, 2006, 31 *Texas Register* 3566, the carrier is liable for all reasonable and necessary medical costs relating to the health care listed in subsection (p) only in the case of an emergency or "preauthorization of any health care listed in subsection (p)… that was approved prior to providing the health care." §134.600(p)(2) states that the non-emergency health care requiring preauthorization includes "outpatient surgical or ambulatory surgical services." Documentation was found to support that "Bilateral L5 transformial epidural steroid injection and Fluoroscopy under monitored anesthesia was authorized October 10, 2008. Authorization started 10/7/2008 through 12/07/2008. The provider billed CPT code 64483 – "Injection(s), anesthetic agent and/or steroid, transformial epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level. Both operative reports state in relative part, "using a 27-gauge 3.5-inch needle, both L5 foramen were entered , and 1 mL of 0.25% Xylocaine and 10mg of Kenalog was placed in both roots." Review of documentation shows services in dispute were authorized and details of operative report support CPT code submitted. The insurance carrier's denial reason is not supported.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 72100 was not included in prior authorization. Separate payment is not recommended.
   - Procedure code 77003 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 64483 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. The provider billed this procedure code with 3 units; however, review of the submitted documentation finds that only 1 unit was prior authorized. Therefore, only 1 unit can be considered for payment. These services are classified under APC 0207, which, per OPPS Addendum A, has a payment rate of $449.34. This amount multiplied by 60% yields an unadjusted labor-related amount of $269.60. This amount multiplied by the annual wage index for this facility of 0.989 yields an adjusted labor-related amount of $266.63. The non-labor related portion is 40% of the APC rate or $179.74. The sum of the labor and non-labor related amounts is $446.37. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,575, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. The OPPS Facility-Specific Impacts file does not list a cost-to-charge ratio (CCR) for this provider. The requestor did not submit documentation of the facility CCR for consideration in this review. Per Medicare policy, when the provider's CCR cannot be determined, the CCR is estimated using the statewide average CCR as found in Medicare's OPPS Annual Policy Files. Medicare lists the Urban Texas 2008 Default CCR as 0.242. This ratio multiplied by the billed charge of $12,497.30 yields a cost of $3,024.35. The total cost

of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $446.37 divided by the sum of all APC payments is 91.03%. The sum of all packaged costs is $655.76. The allocated portion of packaged costs is $596.92. This amount added to the service cost yields a total cost of $3,621.27. The cost of these services exceeds the annual fixed-dollar threshold of $1,575. The amount by which the cost exceeds 1.75 times the OPPS payment is $2,840.12. 50% of this amount is $1,420.06. The total Medicare facility specific reimbursement amount for this line, including outlier payment, is $1,866.43. This amount multiplied by 200% yields a MAR of $3,732.86.

4. The total allowable reimbursement for the services in dispute is $3,886.71. The amount previously paid by the insurance carrier is $0.00. The requestor is seeking additional reimbursement in the amount of $898.40. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $898.40.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $898.40, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 7, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.